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ABSTRACT

This guide describes program components and models of social adjustment services for refugees. Various service components of education and training programs, short term and ongoing services, and mental health services are identified. In addition, a range of existing social adjustment program approaches that reflect successful programs in the United States are outlined. The document is intended to be of use in selecting the social adjustment program that will best suit each community. Finally, it serves as a guide to strengthening existing programs. (Author/APM)

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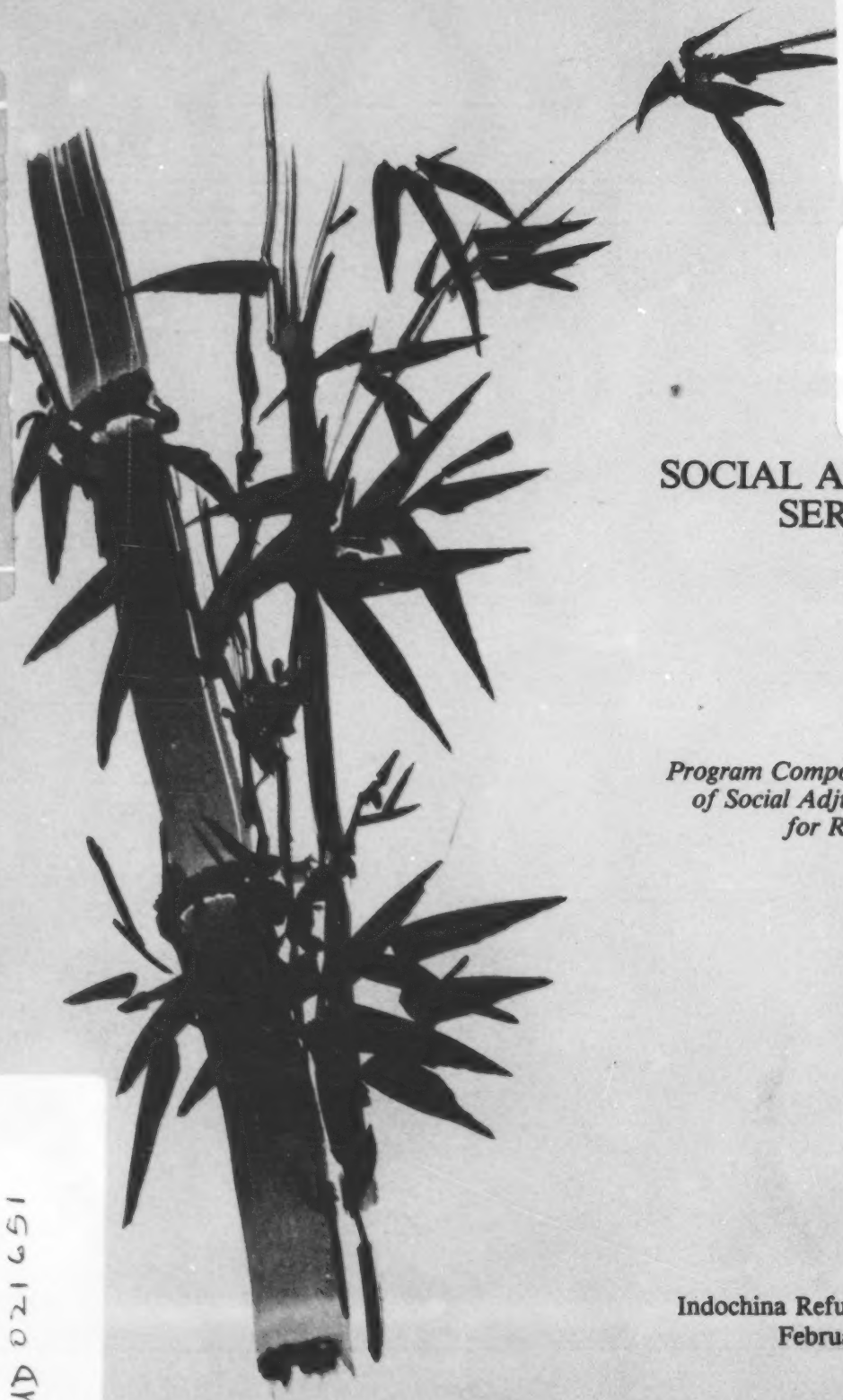

SOCIAL ADJUSTMENT SERVICES

Program Components and Models of Social Adjustment Services for Refugees

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Indochina Refugee Action Center
February, 1981

DOCUMENT SERIES

Program Components and Models of
Resettlement Services for Refugees

I. Refugee Orientation

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IV. Vocational Training and Skills
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SOCIAL ADJUSTMENT SERVICES

Program Components and Models
of Social Adjustment Services
for Refugees

Developed in the
Practitioner Workshop on Social Adjustment
Ward, Colorado
September 24-27, 1980

Laurence Aylesworth, Ph.D., Lead Consultant
and Principal Author

Produced under a Grant from
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Roger Harmon, Ph.D., Project Director
Court Robinson, Project Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

February 25, 1981

Dear Colleagues in Refugee Resettlement:

Enclosed you will find a document describing program components and models of social adjustment services for refugees. The document identifies the service components within a social adjustment program approach, and delineates a range of existing social adjustment program approaches that reflect successful programs currently operating in the United States.

The document is meant to be of use in selecting the social adjustment program approaches that will best fit your community. In addition it will serve as a guide for strengthening existing social adjustment programs. My suggestion is that consideration be given to utilize the necessary program components identified within the document in your program evaluation and/or program development activities.

This document is the third of seven work products being produced in the Practitioner Workshop Project conducted by the Indochinese Refugee Action Center (IRAC). These documents are the work of local service providers who have innovative ways of meeting the needs of refugees. The Office of Refugee Resettlement wishes to thank the participants of the Social Adjustment Services workshop for donating their time and energy. They have made possible a document which will be of assistance to others throughout this country who are working in refugee resettlement.

Sincerely,

Roger P. Winter
Director
Office of Refugee Resettlement

Indochina Refugee Action Center

1025 Fifteenth Street NW, Suite 600
Washington, D.C. 20005
(202) 347-8903

March 3, 1981

Dear Friends:

From September 24-27, 1980, thirteen persons met in Colorado to define program components and models for offering social adjustment services to refugees. Under the leadership of Laurence Aylesworth, lead consultant, they shared their program experience with each other and, through this document, they now share it with you. Following the workshop the lead consultant wrote a draft document summarizing the program approaches identified by the group. This document was mailed to participants for comment, and returned to the Practitioner Workshop Project staff for final editing.

The topics addressed in this document are particularly challenging. The adjustment of refugees to our society is a complex and sometimes painful process. This adjustment is fostered through education and training programs, group activities, and personal counseling and treatment, to name a few of the strategies described here. The reader should be aware that the document is not inclusive of all efforts which should be classified as social adjustment services.

We owe the participants who crafted this document a special dept of gratitude for donating their time and energy to complete a difficult task in a short amount of time. Some of the issues dealt with are ones on which consensus is difficult to obtain. The language in the document is a result of careful deliberation and studious effort on the part of the participants to steer between several divergent points of view and still accurately present effective methods for meeting refugee needs.

The Practitioner Workshop staff wish to thank Dr. Laurence Aylesworth and each of the other participants for their contribution. We also wish to thank Kay Rogers (Chief) and Kathy Do (Project Officer) of the Program Development unit, Office of Refugee Resettlement, for their fine support of this work.

We hope this document is of use to you. We welcome your comments on it, and have included a short questionnaire, should you wish to respond.

Sincerely,

Roger E. Harmon

Roger Harmon, Ph.D.
Project Director
Practitioner Workshop Project

Preface

The purpose of this document is to present service delivery guidelines for programs designed to provide social adjustment services to refugee populations. The document contains a definition of social adjustment and descriptions of necessary components for programs offering social adjustment services. It also includes discussion of program approaches and settings which can be utilized to deliver social adjustment services. Although the experiential basis for this document is primarily work done with Indochinese refugees, the document itself has relevance for service providers, administrators and policy makers concerned with social adjustment programs for other refugee groups as well.

This document does not address all of the social adjustment services as outlined in an Action Transmittal (ORR-AT-80-1) from the Office of Refugee Resettlement. Those services include:

(a) Information and Referral Services
(b) Emergency Services
(c) Health-Related Services
(d) Home-Management Services
(e) Orientation Services

Several of these services are the focus of other documents produced in the Practitioner Workshop Project.* In terms of the social adjustment services outlined by the Action Transmittal, this document discusses both emergency services, which ORR program instructions define as follows:

> "assessment and short term counseling to persons in a perceived crisis; referral to appropriate resources, and the making of arrangements for necessary services."

and health-related services (in this case, mental health-related services), which are defined as follows:

> "information; referral to appropriate resources; assistance in scheduling appointments and obtaining services; and counseling to individuals or families to help them understand and identify their health needs and maintain or improve their health."

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*These documents include Outreach, Information and Referral (for information and referral services); Health-Related Services (for physical health-related services); and Refugee Orientation (for home-management and orientation services). (Additional documents from the Project cover Employment Services; Vocational Training and Skills Recertification; and Refugee Resettlement Service Delivery Approaches.)

Social adjustment, as it is discussed in this document, covers a somewhat broader spectrum of services, all of which focus primarily on alleviating the stresses and uncertainties of resettlement and assisting the refugees in successfully adjusting to American life. The services identified here range from short term services such as case consultation and crisis intervention, to ongoing services such as counseling (for individuals, families and groups) and rehabilitation. Preventive services - including a wide range of education and training activities for refugees, service providers and others in the community - constitute another vital element of social adjustment programs and complement services included in the orientation category.

It is the shared opinion of a great number of local practitioners providing social adjustment and mental health services to refugees, that most of the traditional American modes of mental health service delivery, used in isolation, are inappropriate for Indochinese refugees. Recognizing the high incidence of cultural stress and other adjustment problems among the refugees, local resettlement service providers have responded to the under-utilization by refugees of traditional American mental health services by developing more culturally sensitive service approaches. These often innovative approaches range from social activities and cultural events to long term rehabilitation and treatment. The institutional base of the service providers ranges from voluntary resettlement agencies to special community health center staff, from community-based multiple-service centers to refugee mutual assistance associations (MAA's).

The many successful approaches are alike in one important respect: they all make use of the resources and natural support systems of the refugee communities in their area. Where these refugee communities are small or geographically dispersed, the burden of support falls more heavily on American service providers and communities, but here too there are a variety of services and support networks that can and do reinforce the efforts of mental health and social adjustment service providers.

Refugee social adjustment problems need to be dealt with on an individual basis, but the services that respond to these needs should be community-wide, including the American and the refugee communities. It is strong, supportive refugee communities and organizations working in concert with existing American service providers and community groups - that ultimately must satisfy refugee social adjustment needs.

Acknowledgements

The staff of the Practitioner Workshop Project wish to thank Cindy Coleman for her assistance in planning and facilitating this workshop.

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I. INTRODUCTION

A. Definition

A behavioral definition of social adjustment for the refugee is the degree to which he or she: a) succeeds in minimizing stress caused by cultural misunderstanding and conflicts; and b) succeeds in achieving a normal degree of self-reliance within the host culture. In absolute terms, a refugee has achieved social adjustment when he or she is able to function satisfactorily at home, in school, on the job and in the community.

This definition does not place an intrinsic value on either maintaining traditional cultural patterns or on assimilating rapidly into the American "mainstream." Moreover, the definition of social adjustment for refugees is inclusive of a wide range of structured and unstructured activities for individuals, families and groups. Social adjustment efforts for refugees include traditional mental health interventions, but also a range of other activities. Some examples of the latter are:

(a) a day program for isolated Lao H'mong women conducted by an Indochinese community-based program;

(b) a day program for "drifters" conducted by an Indochinese services team of a community mental health center; and

(c) an alternative-living program for unaccompanied minors conducted by one of the national voluntary agencies (Volags).

Social adjustment for refugees is as much a community concern as it is an individual one, and the breadth of approach ranges from long term personal counseling and treatment to a soccer league or a religious gathering. The resourcefulness of refugee communities in developing and maintaining their own support systems is well-proven. Family, group and agency sponsors have responded time and again to crisis situations or have assisted refugee communities in responding. A great many of the mental health and social adjustment needs of the refugees can be met through education and training activities focused on publicizing and explaining existing community services. Case consultation, crisis intervention, and individual and group counseling should be available on a more selective basis to ensure appropriate attention to the more pressing social adjustment needs of refugees.

B. Sections of the Document

This document is divided into four sections. The first three sections discuss three social adjustment service components, namely:

1. Preventive Services: Education and Training

2. Short term Services

   a. Assessment and Evaluation
   b. Case Consultation
   c. Crisis Intervention

3. Ongoing Services

   a. Individual and Family Counseling
   b. Group Counseling
   c. Rehabilitation
   d. Continuing Care

For each of the components there is discussion of service delivery considerations and staffing suggestions.

The fourth section of the document contains descriptions of approaches being used to deliver mental health services to Indochinese and other refugees. Specifically, there is discussion of:

1. The Individual Practitioner Approach
2. The Mental Health Professional Approach
3. The Consultation Approach
4. The Community-Based Multiple Services Approach
5. The Rehabilitation Approach
6. The Hospitalization Approach

This section also includes discussion of the natural helping system comprised of refugees and Americans who are not trained in providing mental health services, but who respond to the majority of mental health needs within the refugee community. The Appendices of the document contain information about the participants of the workshop in which this document was developed, and provide information about the programs in which those participants are involved. Appendix D includes a rating by participants of the relative effectiveness of various approaches for delivering the types of services discussed in the document. Appendices will serve as a resource for readers who wish to seek further information from the participants.

II. PREVENTIVE SERVICES: EDUCATION AND TRAINING

The purpose of education and training programs is to promote the social adjustment of refugees by providing both the refugee and host communities with: 1) necessary cultural information that could prevent the occurrence of stressful situations caused by lack of cultural awareness; 2) necessary sensitivity and skills to understand and identify refugee mental health needs, and make appropriate referrals; and 3) necessary techniques to provide culturally-sensitive mental health services to refugees.

The education and training services outlined below are arranged according to the specific audience for which the service is targeted. These groups include:

a. General refugee population
b. Sponsors and sponsoring organizations
c. Indochinese leaders, MAA's, and service providers
d. American service providers
e. Indochinese mental health service providers
f. Administrators/policy makers
g. Employers
h. Other American community groups

There exists a good deal of overlap between the concepts of education and training as they relate to refugee social adjustment. In practice, however, training efforts tend to be more intensive than education activities, and thus should be offered on a more selective basis. Program content, staffing and methodology of education and training efforts will differ somewhat according to the specific characteristics and needs of the recipient groups.

For the educational component of education and training services for the target audiences listed above, the following categories of information should be included:

a. Cultural awareness - information on specific cultural factors influencing social adjustment.

b. Resettlement services and resources in the community.

c. Existing and potential adjustment problems: understanding, identification, and appropriate referral.

The training component for these target audiences should cover the above categories of information, but should also include task-oriented instruction in:

d. Culturally appropriate intervention techniques and strategies in the area of mental health and social adjustment.

It is recognized that not all of the target groups listed above will need such training. Specific program content will be described in greater detail as it relates to a particular audience. Staffing and program methodology are discussed in part B of this section.

A. Target Groups for Education and Training Services

1. General Refugee Population

In the process of readjustment there are a great many stressful occasions that could be prevented by offering some primary cross-cultural explanations to the refugees. Areas needing special attention include perspectives on mental health, health care, school systems, adult-youth relationships, and the status of the elderly. The overlaps with a general orientation are obvious, although it is felt that the material discussed below should be presented by someone with experience in, and

sensitivity to, refugee mental health concerns. Presentations should be general in focus but should elaborate on those issues which are most critical to the refugees' adjustment. Cross-cultural factors should be discussed, either as possible bridges to understanding or as possible impediments. A general introduction or orientation to specific community services and systems should also be included. (See Chart I, page 9.)

a) Mental Health Education

Some of the issues to be considered here include stress and depression as common reactions to resettlement pressures, and refugee attitudes toward emotional health. Discussion of cross-cultural factors should focus on Indochinese and American concepts and definitions of mental health. A very brief discussion of mental health services available in the community would also be appropriate.

b) Hospitals/Clinics

A variety of lab procedures should be identified and explained to the refugees to ease the stress of the initial health assessment. It would also be helpful to make refugees aware of the fact that they may receive physical examinations from health practitioners of the opposite sex. Punctuality in keeping medical appointments and taking prescribed medication should be emphasized within the context of a general orientation to health services.

c) School/Classes

Presentations need to explain immunizations, including the fact that all school children - not just refugees - must have immunizations. A discussion and comparison of Indochinese and American approaches to learning could relieve some of the concerns among refugee parents about sending their children to American schools.

d) Adult - Youth Relationships

Generational conflicts caused by different rates of acculturation and ensuing identity crises among young and old are a frequent source of stress for refugees. Discussion of the potential difficulties in this area, and a comparison of refugee and American family and societal expectations might better prepare refugees for these potential conflicts.

e) Elderly

Given the radically different status of the elderly in Indochinese and American societies, the older refugees may have difficulty coming to grips with their new isolation and loss of prestige. An explanation of service programs and living arrangements available for senior citizens may be of interest and value to the elderly refugees.

f) Other

Other topic areas of education for the general refugee population may include other resettlement services, immigration and other legal concerns, insurance and social security, and an introduction to other American ethnic communities.

g) Special Considerations

There are a variety of local factors regarding the characteristics of the refugee populations being served that ought to be considered in the design of an education program.

(1) Ethnicity: An ethnically homogeneous audience is preferable to reduce the distraction of duplicating presentations in a number of languages.

(2) Sex: For Indochinese the audience should be single sex for H'mong; can be mixed for Cambodians, Laotians and Vietnamese.

(3) Age: Suggested age groupings for presentations are:
5-12 years old
13-18 years old
Adults
Elderly

(4) Social/Educational Background: Information should be geared toward the median educational level of a particular ethnic group, if that can be determined.

(5) High/Low Population Density: In areas of low population density, written and audio-visual materials may need to be used without benefit of a live presentation. There should still be some means for refugees to ask questions and get clarification.

(6) Physical Handicaps: A special effort should be made to ensure that the physically handicapped are included and that their special problems are addressed.

CHART I: SOCIAL ADJUSTMENT TOPICS FOR EDUCATION TO THE GENERAL REFUGEE POPULATION

TOPIC	ISSUES	EDUCATIONAL FOCUS
Mental Health Education	Depression Emotional Health	General description of available services; discussion of differing perceptions of mental health.
Health Care (Clinics/ Hospitals)	Lab procedures; Examinations by practitioners of the opposite sex.	General orientation to health services; discussion of making and keeping appointments and use of medication.
Schools/Classes	Stigma of immunizations; unfamiliarity with teaching methods and expectations.	Discussion of school activities, including placement procedures and differing teaching methods and approaches to learning.
Youth-Adult Relationships	Differing rates of acculturation; generation gaps; potential family conflict;identity crises.	Discussion of family and societal roles and expectations.
Status of the Elderly	Isolation; change of role and social position; frequent lack of community support structures.	Orientation to senior citizens programs; community clubs; nursing homes; discussion of differing social status and roles of the elderly.

2. Education and Training for Sponsors and Sponsoring Organizations

Providers of education and training services should ensure that sponsors and sponsoring organizations are offered the following information and skills:

a. General cross-cultural orientation, including a discussion of the refugee's historical background, cultural patterns, and socio-economic realities in this country.

b. Enhancement of communication skills, both verbal and non-verbal.

c. Development of cross-cultural awareness of feelings and behaviors.

d. Knowledge of community resources and support networks.

e. Clarification of overall resettlement program structure and goals.

f. Enhancement of ability to identify refugee mental health needs.

3. Education and Training for Refugee Leaders, Mutual Assistance Associations, and Service Providers

The following expertise and skills ought to be developed in Indochinese leaders, MAA's and service providers.

a. Familiarity with information provided in the education program for the General Refugee Population (See #1. above)

b. Advocacy Skills Training

(1) Enhancement of self-confidence, self-awareness, flexibility, and open-mindedness
(2) Development of communication skills
(3) Methods of follow-up

c. Community Networking, Organization and Development

(1) Understanding of community systems and services
(2) Understanding of political, administrative, and legal systems

d. Manpower Development

(1) Awareness of needs for bilingual/bicultural staff
(2) Recruitment and training of staff
(3) Staff qualifications and requirements

Consideration should be given to training refugee leaders, MAA personnel and other service providers at the times of the day and in a format which is suitable and convenient to their participation. Refugee providers may receive this type of training through in-service programs at their agencies. Some training programs for refugee service providers offer stipends to encourage participation and to make it financially feasible for them to take time from their employment.

4. American Service Providers

Six categories of American service providers have been identified as needing special cross-cultural awareness training relating to their service discipline. These categories include health and mental health; education, including ESL/K-12, vocational training; social and human services; and criminal justice. The four educational training topic areas are cultural awareness, service concerns (specific problems or considerations relating to a service), case detection (identification of mental health needs), and resources (sources for referral and additional support and information).

a. Mental Health Providers

Cultural Awareness: Topics should include Western/Asian cross-cultural perspectives on mental health, and consideration of Asian psychologies for their cultural relevancy and sensitivity to refugee mental health needs.

Service Concerns: Topics include appropriate intervention, therapy, outreach and group work (see Short Term Services for more detail).

Case Detection: This is essentially concerned with distinguishing between appropriate and inappropriate diagnoses.

Resources: These include other mental health service-providers, community resources, MAA's and refugee families, as well as clergy and traditional leaders.

b. Health Providers

Cultural Awareness: Health practitioners should be aware of the Indochinese health systems and their continuing influence among the refugee groups.

Service Concerns: The continuing influence of Indochinese health systems manifests itself actively in the herbal and other folk treatments used by the refugees, and more passively in the expectations about treatment that refugees have developed through use of their own health systems. The impact of these traditional beliefs and treatments on patient care should be more fully explored.

Case Detection: For health practitioners this means primarily the identification of psychosomatic symptoms.

Resources: These should include other health service providers, community resources, MAA's, and refugee families as well as herbalists and other traditional healers.

c. ESL/K-12 Teachers

Cultural Awareness: Teachers of ESL and Kindergarten - 12th grade should be provided with cross-cultural perspectives on Indochinese and American educational systems and teaching methods; i.e.: didactic learning as opposed to inductive/deductive learning.

Service Concerns: ESL/K-12 teachers should be encouraged to make full use of bicultural approaches and bilingual staff in their teaching methods.

Case Detection: The sensitivity of teachers should be enhanced in the identification of behavioral symptons and learning problems as indications of mental health needs.

Resources: These should include other educational providers, community resources, MAA's, and refugee families as well as community schools and tutorial programs.

d. Vocational Training Personnel

Cultural Awareness: Indochinese perspectives on employer/employee relationships should be introduced to the vocational trainer, as well as differing perceptions of occupational roles and status.

Service Concerns: Vocational trainers should be encouraged to incorporate bicultural approaches into career counseling.

Case Detection: The sensitivity of vocational trainers should be enhanced in the identification of behavioral symptoms and learning problems as indications of refugee mental health needs.

Resources: These should include all of the resources listed for the four groups above.

f. Criminal Justice Personnel

Cultural Awareness: Criminal justice personnel should be introduced to Indochinese points-of-view on legal systems and social hierarchy as they apply to law enforcement.

Service Concerns: Criminal justice personnel should be encouraged to train and use bilingual legal advocates in cases involving refugees.

Resources: These should include any of the resources listed for the above groups, with the addition of clergy and religious leaders.

5. Education and Training for Refugee Mental Health Service Providers

A training program for refugee mental health service providers should include the following five topic areas:

a. Psychology

Issues that should be covered here include Western theories of psychology and human behavior, a comparison of Western and Asian perspectives on mental health, and consideration of Asian psychologies and their cultural relevancy and sensitivity to refugee mental health needs.

b. Helping Skills

In developing these skills, the community approach to mental health services should be stressed, i.e. the "socio-therapeutic" approach rather than the "psycho-therapeutic."

Topics should include:

(1) Learning theory
(2) Family contracting
(3) Complexities of interpersonal, group, family, and community relations
(4) Community resources
(5) Social causes of mental illness
(6) Problem-solving skills
(7) Skills involving appropriate and accurate interpretation
(8) Confidentiality.

c. Community Systems

Training should be provided to develop the broker and advocacy roles of paraprofessionals and overcome their feelings of powerlessness and alienation. Bilingual workers should be encouraged to model their advocacy skills to refugee clients, to increase both self-sufficiency and participation in decision-making.

d. Self-Awareness

Training in self-awareness should enable refugee staff to better understand their role in the agency and in the community, to improve their relations with other staff and with clients, and to increase their self-confidence in dealing with staff and professionals from outside the agency.

e. Recruitment and Training

There are a wide range of methodologies effective in training refugee service providers. The following methodologies are recommended:

(1) Participation of persons being trained, in the assessment of the cultural appropriateness of suggested service practices. This should be encouraged through small groups, surveys, and other methods.

(2) Exposure to a wide range of theories, vocabulary and concepts that the paraprofessional might encounter on the job, should be built into the training.

(3) Training should be task-oriented and structured whenever possible.

(4) Role-play provides bilingual workers an opportunity to test out different functions and tasks they might be asked to perform; however, role-play itself is a Western concept and refugee trainers should be fully informed of the purpose and expectation of role-play. Furthermore, there must be trust and positive relationships among trainer, trainee, and the audience for role-play to be successful.

6. Education and Training for Administrators/Policy Makers

In order to increase the sensitivity of administrators and policy makers to the specific social adjustment needs of refugees, an education program should include the following topics:

a. Cultural awareness
b. Research and date analysis on refugee mental health needs
c. Planning and coordination/program development
d. Development of Manpower programs (e.g. Affirmative Action)

7. Education and Training for Employers

Employers would benefit from receiving a general cross-cultural orientation including discussion of Indochinese perspective on employer/employee relationships. Community resources and support networks should also be introduced to the employer.

8. Education and Training for Other Indigenous American Community Groups

To lessen community tensions and facilitate successful cultural adaptation, indigenous American community groups should be offered the opportunity to learn more about the refugees' historical background, cultural patterns, and socio-economic conditions in this country.

Target audiences should include:

a. Minority leaders
b. Civic groups/business groups
c. Schools (children)
d. Churches

This kind of educational program could make use of the media (newsletters, radio and television programs) as well as cultural events (international festivals, community fairs, etc).

B. Education and Training Services: Staffing and Methodology

1. Staffing Considerations

In general, social adjustment educators and trainers should possess the following capabilities:

a) Experience in refugee programs and services

b) Competence in developing content and materials for community education

c) Competence in training

d) Knowledge of relevant cross-cultural information

e) Cultural sensitivity with respect to the target group

f) Knowledge of mental health concerns and concepts as they relate to refugee resettlement

g) Competence in mental health service provision

Although it would be ideal for each staff member to embody all of these qualifications, that would be extremely unusual. The pooling of various capabilities is generally necessary for effective education and training programs. For example, the staff might consist of persons whose relevant capabilities fall in the areas of: a) mental health services and refugee resettlement; b) curriculum and instructional techniques; and/or c) bilingual/bicultural capabilities.

2. Methodology

Education and training programs can make use of written materials and a variety of audio-visual materials (including slides, movies, filmstrips, and tapes). Materials to be translated should be screened for overall cultural relevancy and should be submitted to a linguistic/editorial review process to ensure an accurate translation with appropriate vocabulary.

Field experience suggests that written and audio-visual materials will be most effective when they are incorporated into a live presentation. In low density areas where live presentations may sometimes be impractical, simple written and/or audio-visual materials can be used. Even in these instances, the target groups should have some recourse (through a hotline for example) to ask questions and receive further information. Training in appropriate intervention techniques is virtually impossible through any means other than a live presentation.

Education services can be incorporated into college courses, seminars, lectures, conferences, workshops, community meetings and field work, as well as sites where resettlement services are being provided (health centers, ESL classrooms, etc.).

Training services can be incorporated into the above instructional formats but should also make use of in-service training, field work training, and supervision/counseling.

III. SHORT TERM SERVICES

Short term services are defined as those structured services in which between one and four direct contacts or sessions are provided for a particular client or family situation. These direct contacts or sessions are generally between a refugee mental health service provider and an identified client, family, relative or other case-related service recipient. The services addressed in short term services include:

(a) Assessment and Evaluation

(b) Case Consultation

(c) Crisis Intervention Services

A. Assessment and Evaluation

Assessment and evaluation involves the gathering of relevant client data, the analysis and integration of the data into a culturally appropriate case formulation, and the formulation of a disposition plan, or referral.

Service Considerations:

1. An assessment should follow the recognized procedures for clinical interviewing but must also recognize, and be sensitive to, the cultural values and beliefs of the refugee. When working with a refugee client, the quality of the assessment is fundamentally linked to the establishment of basic trust within the relationship. This point has various programmatic implications; for example:

   a. Trust may often best be established through the provision of services that are generally not considered, in the traditional sense, to be mental health activities.

   b. Assessment procedures with refugee clients may be more time consuming than assessment with American clients.

2. Clinical interviews should make use of a structured format which addresses the particular needs and experience of the refugees and also meets the requirements of local mental health agencies. In the absence of such a structured format, important background information may be neglected, and in addition, local programs may be out of compliance with various county, state and federal regulations.
3. For refugee groups currently arriving in the U. S., culturally relevant norms are not available for personality, intelligence or vocational testing. The cultural bias in tests developed for Americans means that use of these tests with refugees will often lead to misleading conclusions and faulty diagnoses. Under these conditions, test data should never be used as the sole source of information concerning a client but rather be considered within the context of background information concerning personal history, behavioral observations, usual daily activities, and so forth.
   The sets of diagnostic classifications used in American psychiatry should be used primarily or exclusively for administrative purposes, since they are frequently misleading when used for the purpose of assessment or case formulation.
4. Relevant records from other agencies will often prove valuable to the intake, assessment and evaluation process. However, these records should be sought <u>contingent upon obtaining a release of information signed by the client</u>.

If a release of information is obtained and client confidentiality can be assured, information sources which can contribute to an appropriate assessment include health and mental health system records, English as a second language (ESL) and job skill training records, public assistance, school, pre-arrival records and voluntary agency case histories.

B. Case Consultation

Case consultation is the provision of special skills and/or knowledge by a consultant with the aim of helping a consultee in: (a) making an assessment; or (b) arriving at a disposition plan in dealing with a client, family, or other situation.

Service Considerations:

1. Case consultation can be an important strategy in providing cost effective services to sponsors, voluntary agency personnel, refugee family and community members, teachers and others who are involved in the resettlement of refugees.
2. The provision of education and training services to refugee and American service providers and communities is likely to result in more timely and appropriate requests for consultation and referral.
3. Case consultation should be made in a timely manner; requests which are identified as crises or emergency situations should be addressed within four hours, and other requests within twenty-four hours.

   Follow-up should be provided, up to the point where a disposition plan is made.

4. Case consultation is not always a short term service, and often evolves into an ongoing consultation or referral. Some programs provide ongoing case consultation through weekly, bi-weekly or monthly case conferences with agencies which serve a high number of refugees.

5. Consultation requests from refugees are often indirect or disguised, and the provider should be sensitive to the underlying reason for the request. These calls may involve inquiries for general information, vague descriptions of a family member's health or behavioral symptoms, or calls from non-mental health resettlement workers asking, "What constitutes a mental health problem?"

C. Crisis Intervention

Crisis intervention services respond to crises and emergencies that require immediate action. Typically, contact by telephone or in person is made within an hour of receiving the request. The crisis worker must assess the precipitating causes in the current situation and must appraise and use effectively all available resources (including those of the individual, family and/or community), and follow the crisis to a satisfactory resolution. After the immediate crisis has been resolved, the individual or family may be referred for ongoing services or introduced to other community resources.

Service Considerations:

1. From the standpoint of crisis services, a high risk group within the overall refugee population are the recent arrivals and others who speak little or no English. They are at a

distinct disadvantage in their attempts to utilize health, fire, police and other emergency services not only because of the language barrier but also because the refugees often cannot afford a telephone or are unfamiliar with their new community.

2. The following problems are among the most likely to require crisis intervention services.

   a. Personal crises

      1) Suicide threats or gestures
      2) Acute psychotic reactions
      3) Grief and depressive reactions
      4) Anxiety and phobic reactions

   b. Interpersonal crises

      1) Wife and child abuse
      2) Runaways
      3) Marital, inter-generational, and step-family conflict
      4) Refugee-sponsor conflict
      5) Refugee-employer conflict
      6) Conflict between unaccompanied minors and American foster parents

   c. Other crises

      1) Health threat, including accident, surgery, serious illness
      2) Housing loss
      3) Job loss/acute financial problems
      4) Legal difficulty
      5) Community conflict

3. Crisis intervention service delivery approaches include the following:

   a. Eight-hour workday: Calls taken and handled directly by bilingual staff.
      Off-hours: No new calls. Existing clients can call staff member at home.

   b. Eight-hour workday: Calls taken by staff member who refers cases to appropriate bilingual staff.
      Off-hours: Calls taken by staff of mental health center 24-hour line. Referral is made to Indochinese program director who refers to bilingual staff.

c. Eight-hour workday: Calls taken by staff member who refers cases to appropriate bilingual staff.
Off-hours: Indochinese program staff share crisis duties with Indochinese group trained in crisis intervention by the program staff.

d. 24-hours: Local Indochinese MAA provides crisis services on a voluntary basis to members of their ethnic group, sponsors, and others. Bilingual volunteers are responsible for a given geographic area.

e. 24-hours: Three-way phone system involving: a centralized (distant) mental health bilingual staff with toll-free hotline; b) local bilingual resource persons (MAA) who receive limited training from program staff and handle crises in person,with help of staff at the central location and the 3-way phone system.

4. It is commonly known among those working with the refugee community that most crises are handled within the community through its own resources. Natural helping persons outside of family members include priests and monks, mutual assistance association officers and members at-large, neighbors, elders and others who are called upon at any time day or night.

D. Short term Services: Staffing and Delivery Considerations

1. Staffing for short term services must include persons who can engage in unimpeded communication with the client; possess a sensitivity to the cultural and psychological needs of the client; and through their experience, background and training have acquired the expertise needed to conduct an appropriate assessment and/or evaluation. In practice this amounts to the recruitment of bilingual and bicultural refugee staff.

2. Where bilingual-bicultural refugee mental health staff are unavailable, case consultation should be sought.

3. With regard to Indochinese refugees, older males with high prestige in the community are, because of cultural factors, most likely to be effective staff members both in working directly with clients and with the refugee community, and in linking clients with younger Indochinese mental health workers.

4. Short term services should be made physically accessible to the refugee client and his or her family. Accessibility can be insured to rural and low (refugee) density areas either through the deployment of mental health staff to the local area, e.g. a "circuit riding" system; or through the provision of special transportation services to the refugee, his or her family and local service providers.

5. Short term services require ready access to refugee populations - access which can be provided through the existing network of service providers in the area. These agencies generally include, but are not limited to:

   a. Voluntary agencies and other social service providers
   b. ESL, vocational training, and employment programs
   c. Individual, church and other group sponsors
   d. Grade school and high school teachers and related personnel
   e. Health and mental health centers

6. Program evaluation should be conducted to better ensure the effectiveness and appropriateness of short term services. Program evaluation studies should extend beyond checking for the accuracy of client forms, conducting fiscal audits and determining ratios of cost-effectiveness. Program evaluation should address the quality and appropriateness of services rendered.

IV. ONGOING SERVICES

Ongoing social adjustment services are defined as those counseling and support functions which are designed to help the client, family, or community develop more effective ways of dealing with life problems. These services generally extend beyond the crisis situation and involve a minimum of four direct contacts. The social adjustment services that are included within the category of ongoing services are:

1. Individual and family counseling
2. Group counseling and supportive activities
3. Rehabilitation services
4. Continuing care.

These services address many of the social adjustment problems experienced by refugees. The focus in this ongoing services section is specific to the needs of Indochinese refugees. A list of the types of problems encountered is given below. Additionally, this section contains a listing of "high risk" sub-groups within the overall refugee population for whom social adjustment is particularly difficult.

A. Social Adjustment/Mental Health Problems for Refugees

These problems may be overtly disruptive to self, family, or community, but more commonly they simply limit the refugee's ability to work, learn English and in other ways successfully participate in American social institutions. Problems of the Indochinese refugee group which appear frequently include the following:

1. Depression
2. Guilt reactions
3. Phobias and fears
4. Isolation and withdrawal
5. Anxiety reactions
6. Acting out or aggressive behaviors
7. Somatic complaints
8. Chronic preoccupation
9. Chronic dependency
10. Wife and child abuse
11. Marital conflict
12. Intergenerational conflict
13. Refugee/Sponsor conflict
14. Refugee/Employer conflict
15. School adjustment problems
16. Delinquency
17. Runaways
18. Reactions to status loss
19. Reactions to loss of identity
20. Disorientation
21. Alcoholism
22. Compulsive gambling
23. Paranoid states
24. Reactive and chronic psychoses

B. Indochinese High Risk Groups

Specific groups of Indochinese who experience social adjustment problems that are more severe in intensity, frequency or duration are considered "high risk" subgroups. Particular subgroups which are so identified include:

1. Unaccompanied Indochinese children and their American foster parents
2. Homebound women and the elderly
3. "Drifters," a group which consists primarily of ex-service men who have minimal family, community or vocational ties
4. Single heads of households
5. Isolated refugees, including any individual, family or group who, due to geographic, community or cultural factors are isolated from interaction with their own community
6. Refugees with minimal education or no education.

C. Individual and Family Counseling Services are provided to the individual or family directly by one or more counselors. Whether these services are provided in a structured or unstructured setting, the goal generally is to facilitate the individual or family's ability to handle life problems.

These services may be utilized in the treatment of the majority of social adjustment problems experienced by Indochinese. However, it is essential that these services be offered in culturally appropriate form, and that the service providers have either special background or special training, or both.

D. Group Counseling and Group Supportive Activities include those structured activities provided on a regular basis which prevent or remediate social adjustment problems among Indochinese and Americans. Ongoing group counseling and support activities have been conducted on an ad hoc basis in different parts of the country and have proven effective with Indochinese and Americans closely associated with Indochinese. Groups which have been so identified include the following:

Indochinese Groups

1. Drifters
2. Ex-servicemen
3. Men previously of high status adjusting to status loss
4. Isolated women
5. Uneducated/low education persons
6. Children (8 to 12 years of age)
7. Late adolescents (17 to 22 years of age)
8. Elderly
9. Unaccompanied minors
10. Those labeled as chronically psychotic

American Groups

1. Sponsors
2. Foster parents
3. Rural service providers

Transportation services are generally an essential component in providing group counseling or group supportive services; appropriate transportation arrangements will vary considerably depending on the characteristics of the group.

E. Rehabilitation Services include those activities which lead the socially, emotionally or physically disabled individual to self-sufficiency as: 1) an effective family member; 2) a gainfully employed individual; and/or 3) a person capable of effective social participation. Rehabilitation services include:

1. Day treatment
2. Sheltered workshop
3. Alternative living situation and independent living skills
4. Vocational rehabilitation counseling
5. Continuous care

Most persons requiring rehabilitative services are found among those who suffer from reactive or chronic psychoses, chronic depression, isolation, fears and phobias, eating disorders, anxiety reactions;or those who lack social or survival skills. The exception to this is the unaccompanied minors, who must be considered separately within the rehabilitative services.

1. Day treatment involves providing a series of structured group activities to clients for a minimum of four hours per day, three days a week.

2. Sheltered workshops are supervised work settings which allow clients gradual reacquisition of the skills needed for reentry into the work force and include the acquisition of independent living skills.
3. Alternative living situations include 24-hour living facilities such as half-way houses, supervised living situations and group homes. These facilities are appropriate for the chronic mental health clients as alternatives to unaccompanied minor youth anticipating emancipation from their foster families.

Indochinese unaccompanied minor youth whose families remain in Southeast Asia present a special problem in social adjustment. In many situations they have a limited or interrupted education, little or no English language skills, conflicting cultural values, and are dependent both socially and legally. Foster home care for many is the appropriate setting. However, for those who exhibit a higher degree of maturity and emotional stability, a semi-independent alternative living service (apartment living or group boarding home) is a recommended alternative. This service provides guided activities and interaction for youth in the greater society through which they gradually acquire necessary life skills needed to manage the societal expectations of adulthood.

4. Vocational rehabilitation counseling involves counseling services for individuals having a disabling condition which constitutes a substantial handicap to employment.

5. Continuing care comprises long term regiments or temporary 24-hour care. These services are provided primarily to the acutely disturbed or chronically maladjusted population. The services include medical management for those in need of psychotropic medication, and short term hospitalization for those in need of such services. They are designed to help the individual regain or maintain a functional level of behavioral stability.

F. Ongoing Services: Staffing Considerations

In designing and implementing an ongoing social adjustment service program it is essential to:

1. Employ persons who, through experience, background, or training, have the expertise to facilitate the client's coping skills.

2. Ensure that there is unimpeded communication with the client(s).

3. Ensure that staff hired within the program appropriately represent the ethnic group of those being served. Serious consideration must be given to dividing services by ethnic group as well.

G. Ongoing Services: Delivery Considerations

The following considerations in establishing a social adjustment program for refugees are essential if the program is to be successful:

1. The service provider must have an understanding of the psychological, social, and cultural needs of the client(s).

2. The program or service must be seen as legitimate and acceptable within both the refugee and American communities.

3. The program or service must be accessible, both emotionally and physically, to the client and his or her family. Depending upon the physical location, service providers must ensure that the costs of transportation are planned for and can be met before instituting a program or service in a given geographical location.

4. Adequate screening and evaluation procedures for clients must be instituted to ensure appropriateness of ongoing services.

5. Adequate communication and dissemination systems to both the refugee and American communities are essential.

6. There must be access and linkage to community referral networks to include, but not be limited to:

   a. Volags and other social service providers
   b. Vocational and other rehabilitation services
   c. Crisis intervention services
   d. Evaluation and review services
   e. Hospitalization, medication, and alternative living services

7. Ongoing program evaluation and feedback systems to ensure the adequacy and appropriateness of the service are mandatory.

V. MENTAL HEALTH SERVICE DELIVERY APPROACHES FOR INDOCHINESE (AND OTHER) REFUGEES

Mental health services which promote social adjustment are provided by a range of practitioners working in a number of settings. Various approaches which have been identified by the working group are listed below. It should be understood that in many locales a number of the following approaches are used to provide refugee care. Also, in each of the different approaches, a range of services may be offered.

A. The Individual Practitioner Approach - involves individual practitioners providing mental health services in private settings or operating out of institutional settings such as churches, clinics, hospitals, etc. These practitioners may be Indochinese or American, and their background and training in mental health services may vary greatly.

B. The Mental Health Professional Approach - involves a special services program staffed by Indochinese or American mental health professionals and bilingual/bicultural Indochinese paraprofessionals. Services include traditional forms of treatment and may include non-traditional forms of treatment as well.

C. The Consultation Approach is a non-specialized program in which consultation is provided by knowledgeable mental health professionals. This approach is often used in geographic areas having a low density of Indochinese refugees. Direct mental health services are not delivered and mental health cases are treated through the use of ongoing or ad hoc consultative services.

D. The Community-Based Multiple Services Approach - involves the delivery of mental health services within a broader context of service delivery which typically includes job counseling, housing assistance, advocacy, transportation assistance, information and referral, etc. These programs generally are found in areas which have a high concentration of refugees.

E. The Rehabilitation Approach - involves a variety of intervention strategies such as alternate living skills, social rehabilitation and vocational rehabilitation. The general goal is to return the individual to functioning as effectively as possible in order that he or she may become self-supporting.

F. The Hospitalization Approach - involves hospitalizing clients needing mental health services and is generally used when other service approaches are not available. This approach is generally used when client behavior becomes so disruptive that other treatment modes are not adequate, and when the individual presents a danger to self, danger to others, or is gravely disabled.*

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*Some crises raise the question of voluntary or involuntary hospitalization. There have been instances when Indochinese refugees have been hospitalized inappropriately because there was no bilingual/bicultural staff available at the time of initial assessment leading to inpatient hospitalization. Special mental health projects should have linkages with existing hospital services to provide case consultation and/or interviews for hospital emergency room psychiatric staff. Where these linkages have not been developed, education and training should be given to all personnel who assess cases that may result in hospitalization. Refugee mental health project staff should be trained in local laws governing involuntary hospitalization and should be involved in all stages of this process from the earliest point possible.

In addition to the above approaches, numerous social adjustment services are offered through what can be termed the natural helping system. Indeed, it is the consensus of the working group that the majority of responses to mental health needs in refugee communities is provided through this natural helping system comprised of Indochinese and Americans who are not trained in providing mental health services but who can be called upon for support.

From 1975, when Indochinese refugees first came to the U.S., Indochinese individuals have assisted each other both through help in times of stress and through social and cultural activities which have a preventive mental health benefit. In some areas, this assistance has been totally informal while in others, it has also included support organized by self-help groups - commonly called mutual assistance associations (MAA's). Increasingly, these MAA's are seeking ways to establish formal structures for providing social services to their own people. Efforts should be made to encourage the strengthening of this MAA element of the natural helping system, as well as strengthening the link between the mutual assistance associations and the more formal structures used to provide mental health services.

/ Appendix A /

The Practitioner Workshop Project
Social Adjustment Workshop

The Practitioner Workshop Project is a project of the Indochina Refugee Action Center, conducted under a grant from the Department of Health and Human Services, Office of Refugee Resettlement (HHS/ORR) (Grant #96-P-10003-3-01).

A series of seven workshops is being held. Each workshop deals with a different social service or services which can be provided Indochinese and other refugees through Department of Health and Human Services Title XX and/or Refugee Resettlement Program social services funding. The workshops are:

Orientation	- August 1980
Health-Related Services	- September 1980
Social Adjustment	- September 1980
Vocational Training and Skills Recertification	- October 1980
Employment Services	- October 1980
Outreach, Information and Referral	- November 1980
Refugee Resettlement Service Delivery Approaches	- December 1980

The goals and objectives of these intensive workshops are to:

- develop practical models and approaches to serve as examples of effective programs and as stimulants to new, quality project development in resettlement communities;
- develop models to stimulate acceptance and to serve as a guide for state human service administrators charged with making IRAP social service funding decisions;
- facilitate communication between resettlement workers regarding approaches used in other locales;

- provide input from knowledgeable local resettlement practitioners into national program operations; and
- increase the very limited body of knowledge on effective resettlement practice in very pragmatic terms -- to move forward the state-of-the-art.

Each workshop is comprised of approximately 10 service providers who are involved in delivering social services to Indochinese refugees. Each workshop is three days in length, and is directed by a lead consultant designated by project staff. The lead consultant has primary responsiblity for drafting a workshop report. For each of the workshops, the report includes an introduction, with a definition of the service(s); necessary program considerations; a description of appropriate delivery settings; and various models or approaches for delivering the service(s). The report is reviewed by project staff, workshop participants and by HHS/ORR, and then distributed to major refugee resettlement information distribution sources and to resettlement practitioners.

The social adjustment workshop was held at Gold Lake Ranch, Ward, Colorado, September 24-27, 1980. It was led by Laurence S. Aylesworth, Ph.D., Program Director, Asian Pacific Development Center, Denver, Colorado. The workshop was attended by 13 individuals who are involved in the delivery of social adjustment services to refugees. The names of the participants are attached.

Appendix A

Implementation Phase

This second six-month phase of the project will implement the practical models of service delivery developed in the workshops. Short-term, on-site assistance will be available to local resettlement practitioners who express a need for assistance in the program development areas covered in the workshops. Practitioners involved in the workshop phase will be linked with communities requesting implementation support.

The objectives of this implementation phase are to:

1. stimulate the development of effective refugee services in areas where services are either inadequate or non-existent;
2. encourage coordination among service programs, particularly in high-impact areas; and
3. assist specific groups (e.g. MAA's, voluntary agencies and other local service providers) in enhancing their capacity to provide services to refugees.

The implementation phase of the project will be directed by a coordinator. The coordinator will assist specific agencies and/or communities who indicate a need of program development by matching them with experienced local resettlement practitioners identified through the workshop process. These practitioners will provide on-site technical assistance in a number of communities around the country. Services provided on-site may include the following:

a. identification of the delivery model(s) appropriate to the agency/community and its specific needs
b. development of service delivery plans, including specific modifications and implementation concerns
c. follow-up assessment and evaluation.

Appendix B

PRACTITIONER WORKSHOP PROJECT

Social Adjustment Participants

September 25-27, 1980
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Ward, Colorado

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Appendix B

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Appendix B

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CHART II: PROGRAM DESCRIPTIONS FOR WORKSHOP PARTICIPANTS

PROGRAM	SPECIAL FOCUS/EMPHASIS	Assessment/ Evaluation	Case Consultation	Crisis Intervention/ Emergency Service	Individual Counseling	Family Counseling	Group Counseling & Supportive Activities	Rehabilitation Services	Continuing Care Services	Education to the Indochinese Community	Education to the American Community	Training to American Service Providers	Training to Refugee Non-Mental Health Service Providers	Training to Refugee Mental Health Service Providers	
Rehabilitation Institute (Harry Allen)	The Rehabilitation Institute provides training for rehabilitation counselors, but no direct services.														
Asian Pacific Family Outreach (Mary Arimoto)	Asian Pacific Family Outreach is a community-based social service agency providing social adjustment services; where a mental health need is assessed, a referral is made.	•	•	•	•	•	•			•	•	•	•	•	
Asian Pacific Resource Center (Laurie Aylesworth)	The Asian Pacific Resource Center provides services to a geographically dispersed refugee population. Given this dispersion, case consultation is frequently provided.	•	•	•	•	•	•	•	•			•	•	•	
Refugees of Indochina Culture Education (RICE) (Bruce Bliatout)	The RICE program places a special emphasis on using traditional healers and refugee community elders or "gate-keepers" in addressing social adjustment needs.	•	•	•	•	•	•			•	•	•	•	•	
Indochinese Mental Health Project (Don Cohon)	In the past four years, in addition to providing direct services, the Project has developed a comprehensive seminar curriculum to teach Western theories of human behavior.	•	•	•	•	•	•		•	•	•	•	•	•	

Appendix C

CHART II: PROGRAM DESCRIPTIONS FOR WORKSHOP PARTICIPANTS (Page 2)

PROGRAM	SPECIAL FOCUS/EMPHASIS	Assessment Evaluation	Case Consultation	Crisis Intervention/ Emergency Services	Individual Counseling	Family Counseling	Group Counseling & Supportive Activities	Rehabilitation Services	Continuing Care Services	Education to The Indochinese Community	Education to The American Community	Training to American Service Providers	Training to Refugee Non-Mental Health Service Prov.	Training to Refugee Mental Health Service Providers
Lutheran Children and Family Service (Carol Hammarberg	LCFS provides reception and orientation for unaccompanied minors, and placement in either specialized foster care or a semi-independent living situation.	•	•	•	•		•	•	•					
Asian Counseling and Referral Service (Dave Okimoto)	ACRS incorporates mental health services for refugees into a pan-Asian multi-service approach, providing refugee resettlement and community education services.	•	•	•	•	•			•	•	•	•	•	
Iowa Refugee Service Center (Somsak Saythongphet)	Iowa Refugee Service Center provides bilingual social service counselors - they are not strictly mental health counselors.	•		•	•	•	•			•	•	•	•	
Indochinese Cultural and Service Center (Sokhom Sin)	The mental health project at ICSC provides counseling and other services for more serious adjustment problems. Counselors are encouraged to incorporate Eastern and Western techniques.	•	•	•	•	•	•			•	•	•		•
Indochinese Community Health and Education Project (Jan Lee Wong)	The primary focus of the ICHE Project (now the Pacific Asian Latino Training Project) is on mental health education and training for paraprofessionals in community mental health.		•	•						•	•	•	•	•

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/ Appendix D /

Effectiveness Ratings of Refugee Social Adjustment Service Delivery Approaches

The six approaches to social adjustment service delivery that are identified in this document, were recognized as differentially effective in meeting the social adjustment needs of refugees but none of the existing programs were found to offer the entire range of services, and each was reported to have some limitations. Participants in the Social Adjustment Workshop represented each of the six models with the exception of the hospitalization model. These participants have rated the relative effectiveness of these approaches in providing an identified range of social adjustment services. The results of the ratings by participants are presented below in Chart III.

These ratings indicate that the community based multi-services and mental health professional models provide most services effectively but are most limited in the areas of rehabilitative and continuing care services. Conversely, the rehabilitation model is at least somewhat effective in the areas of rehabilitation, assessment and evaluation, group services, continuing care and training to refugee mental health service providers but was rated as less than somewhat effective in the remaining eight areas. The case-consultation model was at least somewhat effective in the provision of assessment and evaluation, case-consultation, family counseling, education to the Indochinese and American communities and training to American service providers, but was less effective in the remaining seven service areas.

Appendix D

The individual practitioner model was rated to be at least somewhat effective in the areas of assessment and evaluation, case-consultation, crisis intervention, and individual and family counseling. The hospitalization model received moderate to extreme effectiveness ratings in the provision of assessment and evaluation and crisis intervention but was rated as less than somewhat effective in the remaining eleven areas.

Various factors should be considered in the decision to fund and implement local social adjustment programs for refugees. Mental health professional and community based multi-service programs represent two of the more effective service delivery models but generally require a high density of refugees in order to be cost effective. In low density areas, case-consultation or individual practitioner models may represent the only viable alternatives, and in this case steps may need to be taken to insure that other social adjustment service needs are addressed.

CHART III: EFFECTIVENESS RATINGS OF REFUGEE SOCIAL ADJUSTMENT SERVICE DELIVERY APPROACHES.

SERVICE DELIVERY APPROACHES	SOCIAL ADJUSTMENT SERVICES												
	Assessment/ Evaluation	Case Consultation	Crisis Intervention/ Emergency Services	Individual Counseling	Family Counseling	Group Counseling & Supportive Activities	Rehabilitation Services	Continuing Care Services	Education to the Indochinese Community	Education to the American Community	Training to American Service Providers	Training to Refugee Non-Mental Health Service Prov	Training to Refugee Mental Health Service Providers
Individual Practitioner Approach	4.2	3.8	3.8	3.8	4.3	2.0	1.1	2.1	1.9	2.1	1.8	1.6	2.0
Mental Health Professional Approach	4.6	4.1	4.5	4.9	4.7	3.5	2.4	2.5	3.8	4.0	4.1	4.3	4.3
Consultation Approach	4.5	4.6	2.8	2.8	3.1	1.3	1.3	1.6	3.1	3.7	3.1	2.3	1.6
Community Based Multi-Service Approach	4.2	4.6	4.1	4.8	4.6	4.1	1.7	2.7	4.1	3.7	3.8	4.7	4.5
Rehabilitation Approach	4.3	2.3	1.4	2.4	2.7	4.3	4.4	4.6	2.6	1.9	2.2	1.3	3.4
Hospitalization Approach	4.3	1.6	4.9	2.5	1.7	1.5	1.2	1.5	1.2	1.1	1.1	1.1	1.2

Ratings
1 = Not effective
2 = Minimally effective
3 = Somewhat effective
4 = Moderately effective
5 = Extremely effective

Number of Participants: N = 12